Health Care
Innovation Initiative

Patient Centered Medical Homes (PCMH)
Technical Advisory Group (TAG) Recommendations and Program Information

PCMH program information

- A Sources of value
- B Care delivery model
- C Patient engagement
- D Eligibility requirements
- E Activities
- F Training and supports
- G Provider report design
- H Quality metrics

A PCMH sources of value

Sources of value

- **Appropriateness of care setting and forms of delivery** (e.g., increase in PCP visit to reduce ED utilization for medical conditions)
- **Increased access to care** (e.g., open office hours, open scheduling for walk-in appointments, and after-hours availability)
- **Improved treatment adherence** (e.g., adherence to mood stabilizer regimen, adherence to scheduled PCP visits)
- **Medication reconciliation**
- **Appropriateness of treatment**
- **Enhanced chronic condition management** (e.g., more frequent monitoring of A1c for diabetics)
- **Referrals to high-value medical and behavioral health care providers**
- **Reduced readmissions** through effective follow-up and transition management

B PCMH care delivery improvement model

	Stage 1: Providers in transition	Stage 2: Emerging model	Stage 3: Steady-state transformation
Primary patient prioritization	• All patients in PCMH • Primary PCMH prioritization[1] and focus on patients with **chronic conditions and existing PCP contact** due to near-term value capture	• Additional prioritization and focus on patient groups including: ▫ **Chronic conditions but no PCP contact[2]** ▫ **Patients at risk** of developing chronic condition	• **Broader focus on all patients** including healthy individuals
Focus for care delivery improvements	• Changes in **direct control of PCP** including ▫ Enhance access and continuity (e.g., office-hours, after-hours access) ▫ Provide self-care support and community resources including wraparound support ▫ Plan and manage care by developing evidence-based care plan with input from patient and their family ▫ Refer to high-value providers • Greater emphasis on **diagnosis and treatment of low-acuity behavioral health needs** • **Measure and improve performance**	Additional priorities to include: • Practice at **top of license** including use of extenders • **Joint decision-making with behavioral health providers** and other specialist • Improve integrity of **care transitions** • Address **social determinants of health**	Additional priorities to include: • **Multi-disciplinary team-based care** including regular interactions in-person • **Full IT connectivity across providers** including interoperable records • **Co-location of behavioral and physical healthcare** where feasible • **Health and wellness screenings, outreach, and engagement**

1 Prioritization of patient sub-groups to be conducted through the selection of quality and utilization measures, types of practice transformation support, allocation of staff resources for tracking and monitoring, and reporting focus 2 Based on claims

C TAG recommendations on patient engagement

	Recommendation	Examples
Educate patients	• Orient patients on PCMH program • Teach patients how to stay engaged in one's own health • Educate patients on options in their own care to increase patient autonomy • Create expectation for patients that their first visit is about getting to know PCP	• Play "Welcome to Medicaid" videos and other interactive modules in clinic lobby, similar to Medicare introductory materials • Provide patients with toolkit covering key topics associated with one's own care, e.g.: "How to keep track of your medicine" • Give patients plastic cards that say, "Stop! Before you go to the ER call this number", which leads to a staff nurse line • Provide patients with an actionable menu of options in care planning • Build in more time during initial patient visit to 'get to know' patient
Eliminate barriers to care	• Actively address social determinants of health (e.g., food, employment, transportation, family) • Utilize existing tools to screen for social determinants of health in pediatrics • Engage/connect with high needs behavioral health members in Health Homes	• Build formal relationships with local social service agencies (e.g., through care coordinators) • Transportation carriers in Memphis already offer reimbursement to those in need • Establish partnerships with legal entities to provide legal aid
Incentivize patients to engage	• Allow formal incentives for patients to engage in their own care (if feasible)	• Offer a gift card for each appointment attended on schedule and on time

D PCMH provider eligibility requirements

Commitment	• Stated commitment to the program
Minimum panel size	• Requirement of 500 patients with a single MCO to enter program
Practice type	• Eligible primary care TennCare practice type (i.e., family practice, general practice, pediatrics, internal medicine, geriatrics, FQHC, local health department) with one or more PCPs (including nurse practitioners)
Personnel	• Designation of PCMH Director
Activities	• Commit to PCMH activity requirements (see next page)

E PCMH provider activity requirements

Training	• All practices will have access to 2 years of practice transformation training and support through the State's provider training vendor. • Practices are required to participate in trainings, including learning collaboratives and conferences
NCQA Accreditation	• Maintain Level 2 or 3 PCMH accreditation from the National Committee for Quality Assurance (NCQA) ***OR*** • Meet Tennessee's specific activity requirements and begin working towards meeting NCQA's 2017[1] PCMH accreditation, once standards are finalized
Tools	• Commit to use of the state's shared Care Coordination Tool

[1]NCQA's 2017 recommended standards are expected to be finalized in March 2017. The recommended standards are available here: http://www.ncqa.org/Portals/0/PublicComment/PCMH%202017%20Recommendations%20Table.pdf?ver=2016-06-13-094129-053

E Tennessee specific activity requirements (1/4)

TAG RECOMMENDATION

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
1 Patient-centered access	**Patient-centered appointment access (Element A)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on the required factors	• Provide same-day appointments for routine and urgent care[1] • Provide routine and urgent care appointments outside regular business hours[1]
	24/7 Access to Clinical Advice (Element B) The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:	• Providing timely advice by telephone[1]
	Electronic Access (Element C) The following information and services are provided to patients/families/ caregivers, as specified, through a secure electronic system	• Clinical summaries are provided within 1 business day for more than 50% of office visits[1]
2 Team-based care	**The practice team (Element D)** The practice uses a team to provide a range of patient care services by:	• Defining roles for clinical and nonclinical team members[1] • Identifying team structure and the staff who lead and sustain team based care • Holding scheduled patient care team meetings or a structured communication process focused on individual patient care

Factors may be retired in NCQA 2017 standards

1 Recommended by TAG member

E Tennessee specific activity requirements (2/4)

TAG RECOMMENDATION

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
3 Population health management	**Use data for population management (Element D)[1]** At least annually the practice proactively identifies populations of patients and reminds them, or their families / caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:	• At least three different chronic or acute care services[1] • Patients not recently seen by the practice[1]
	Implement evidence-based decision support (Element E)[1] At least annually the practice proactively identifies populations of patients and reminds them, or their families / caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines for:	• A mental health or substance use disorder[1] • A chronic medical condition[1] • An acute condition[1] • A condition related to unhealthy behaviors[1]

1 Recommended by TAG member

E Tennessee specific activity requirements (3/4)

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
4 Care manage-ment support	**Identify patients for care management (Element A)** The practice [*shares a list developed through a systematic process as identified by the Care Coordination Tool of at least top 10% of patients*][1] who may benefit from care management. The process includes consideration of the following:	• Behavioral health conditions[2] • High cost/high utilization[2] • Poorly controlled / complex conditions • Social determinants of health[2] • Referrals by outside organizations
	Care planning and self-care support (Element B) The care team and patient / family / caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for 75% of all patients prioritized for care management [*i.e., top 10% of patients across various factors*][3]:	• Incorporates patient preferences and functional / lifestyle goals • Identifies treatment goals • Assesses and addresses potential barriers to meeting goals[2] • Includes a self-management plan[2] • Is provided in writing to the patient / family / caregiver[2]
	Use electronic prescribing (Element D) The practice uses an e-prescription system with one of the following capabilities[4]:	• More than 50% of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies • Performs patient-specific checks for drug-drug and drug-allergy interactions • Alerts prescribers to generic alternatives

Factors may be retired in NCQA 2017 standards

1 [Text] added to above NCQA Element A to specify target population as most high risk patients
2 Recommended by TAG member
3 [Text] is consistent with NCQA's intention to tie Element B with Element A above
4 NCQA does not specify "one of the following"; instead gives a higher score for meeting more factors

E Tennessee specific activity requirements (4/4)

Practices without NCQA level 2 or 3 accreditation will be expected to meet TAG recommended Tennessee specific activities that will prepare them for NCQA 2017 accreditation.

Standard	Elements with descriptions	Required factors
5 Care coordi-nation and care transit-ions	**Referral tracking and follow-up (Element B)** The practice will do the following:	❑ Track referrals until the consultant or specialist's report is available, flagging and following up on overdue reports[1]
	Coordinate care transitions (Element C) The practice will do the following:	❑ Consistently obtains patient discharge summaries from the hospital and other facilities[1] ❑ Proactively identifies patients with unplanned hospital admissions and emergency department visits[1] ❑ Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit[1] ❑ Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners
6 Perform-ance measure-ment and quality improve-ment	The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience[1]	No elements or factors required for this standard

TN

1 Recommended by TAG member

F TAG recommendation on training and practice transformation services

Initial assessment	• An initial, rapid, standardized assessment to develop a tailored curriculum for each site to establish baseline level of readiness for transformation • Focus of assessment to be strengths and gaps in workforce, infrastructure, and workflows as they relate to capabilities and transformation milestones, prioritizing areas for improvement
Practice transformation support curriculum	• Develop and execute a standard curriculum that can be tailored for each primary care practice site based on the needs identified in the pre-transformation assessment • Should cover 1st and 2nd years of transformation including frequency and structure of learning activities • Curriculum may include content structured through the following: – Learning collaboratives – Large format in-person trainings – Live webinars – Recorded trainings – On-site coaching
Semi-annual assessment	• Conduct assessments of progress toward each practice transformation milestone every 6 months; document progress

Important to account for differing needs across practice profiles (e.g., size, urban / rural)

G TAG recommendation on provider reports

- **Practice Overview**
  - Basic information (e.g., attributed beneficiaries)
  - Required activity milestone completion
  - Practice support progress review (e.g., training milestones)
- **Quality performance report**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks
- **Total cost of care**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks
  - For large practices only: Shared savings due
- **Utilization performance report**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks

- Align reporting (e.g., format, style) as much as possible across MCOs
- Be transparent in the event of reporting errors

F PCMH quality and efficiency measures

	Core measures	Measures for reporting only
Quality metrics for adults	• Adult BMI screening • Antidepressant medication management • Asthma medication management • Comprehensive Diabetes Care[1] • Statin therapy for patients with cardiovascular disease	• Avoidance of antibiotics in adults with acute bronchitis
Quality metrics for children	• ADHD/ADD follow-up care • Asthma medication management • Immunization composite[2] • EPSDT screening composite[3] • Weight assessment and nutritional counseling	• Appropriate treatment for children with upper respiratory infection
Efficiency metrics	• All-cause hospital readmissions rate • Ambulatory sensitive ED visits • Inpatient admissions per 1,000 member months • ED visits per 1,000 member months • Mental Health Utilization, inpatient only	• Inpatient average length of stay

1 Includes six separate measures
2 Includes two separate measures
3 Includes five separate measures

F Core quality metrics for adults (1/2)

	Details	Source
Adult BMI screening	• % of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement year or the year prior	• HEDIS (ABA)
Antidepressant medication management	• % of 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime; report – Acute phase - % who remained on antidepressant medication for at least 84 days (12 weeks) – Continuation phase - % who remained on antidepressant medication for at least 180 days (6 mo.)	• HEDIS (AMM)
Asthma medication management	• The % of members 5-85 years of age during the measure-ment year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. • The rate included in this measure would is the % of members in each age group who remained on an asthma controller medication for at least 75% of their treatment	• HEDIS (MMA)

F Core quality metrics for adults (2/2)

	Details	Source
Comprehensive diabetes care	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes who had each of the following: – An eye exam (retinal) performed – Most recent blood pressure reading less than 140/90 mm Hg (controlled) – An HbA1c test performed in the measurement year – Most recent HbA1c level during the measurement year less than 7% – Most recent HbA1c level during the measurement year greater than 9% – Received medical attention for nephropathy	• HEDIS (CDC)
Statin therapy for patients with cardiovascular disease	• % of males age 21-75 and females age 40-75 who were identified as having clinical ASCVD[1] and were dispensed at least moderate intensity statin therapy during the measurement year • % of males age 21-75 and females age 40-75 who were identified as having clinical ASCVD[1] and were dispensed at least moderate-intensity statin therapy that they remained on for at least 80 percent of the treatment period	• HEDIS (SPC)

1 Atherosclerotic cardiovascular disease

F Core quality metrics for children (1/2)

	Details	Source
ADHD/ADD Follow-up Care	• % of children age 6-12 who were newly prescribed ADHD medication and had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed (includes both a 30-day Initiation Phase and a 270-day Continuation and Maintenance phase)	• HEDIS (ADD)
Asthma medication management	• % of members 5-85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The rate included in this measure is the % of members in this age group who remained on an asthma controller medication for at least 75% of their treatment	• HEDIS (MMA)
Immunization composite	• % of adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap or one Td by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. • % of children 2 years of age who had 4 DTaP), 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, and 4 PCV by their second birthday	• HEDIS (CIS, IMA)

F Core quality metrics for children (2/2)

	Details	Source
EPSDT screening rate	• % of members who turned 15 months old during the measurement year and who had 6 or more well child visits with a PCP from 31st day from birth to 15 months of life[1] • % of members age 30 months who had a well-child by 18, 24, and 30 months of age • % of members age 3-6 who had 1 or more well-child visits with a PCP during the measurement year • % of members age 7-11 who had 1 or more well-child visits with a PCP during the measurement year • % of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	• HEDIS / TennCare (W15, TennCare, W34, TennCare, AWC)
Weight assessment and nutritional counseling	• Weight assessment and counseling for nutrition and physical activity for children/adolescents ages 3-17 including BMI	• HEDIS (WCC)

1 HEDIS "Well Child visits in the first 15 months of life" measure does not cover prenatal, newborn, 3-5 day, and 'by 1 month' preventive visits listed in the Bright Futures periodicity schedule